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MORBIDITY AND MORTALITY WEEKLY REPORT

National Fire Prevention Week — October 6–12, 1996

The National Fire Protection Association (NFPA) has designated October 6–12, 1996, as National Fire Prevention Week. The theme for the week is "Let's Hear it For Fire Safety! Test Your Detectors."

The United States has the highest annual death rate from fires of all developed countries (2.1 per 100,000 persons). This problem disproportionately affects the southeastern states, particularly during December–February, when the number of residential fire-related deaths and injuries is 1.5–3.3 times that of summer months. Widespread use of noncentral home heating sources (e.g., wood-burning stoves and portable space heaters) are major causes because they often are improperly placed and/or left unattended.

A substantial proportion of the injuries and deaths result from poor basic fire-safety practices. A study by the U.S. Consumer Product Safety Commission during January 1995 indicated that most homes in which a fire occurs are not equipped with a functioning smoke detector (*1*).

NFPA recommends that every home in the United States be equipped with one functioning smoke detector in each bedroom area and on every habitable floor of the residence to protect the home and its residents from fires. In addition, NFPA recommends timing smoke detector battery replacement with the October clock change from daylight savings time to standard time through the "Change Your Clock, Change Your Battery" slogan.

One of the national health objectives for the year 2000 is to increase the presence of functional smoke detectors to at least one on each habitable floor of all inhabited residential dwellings (objective 9.17) (*2*). Additional information about residential fires is available from CDC's Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, telephone (770) 488-4652.

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Home Radiator Burns Among Inner-City Children — Chicago, September 1991–April 1994

Contact with hot surfaces is a cause of substantial morbidity among children (*1,2*). In 1993, an estimated 1881 children visited emergency departments for treatment of burns related to nonvehicle radiators in the United States (*3*). This report summarizes the investigation of radiator burns among children aged 0–19 years living in a Chicago housing project and provides recommendations for preventing radiator burn injuries.

From September 1991 through April 1994, a total of 10 children were treated in one pediatric clinic in Chicago for burns resulting from contact with home radiators. The children ranged in age from 7 months to 5 years; six were aged <2 years, and six were boys. Cases were identified by monitoring pediatric visits to the clinic for children who had burns associated with contact with a home radiator.

Eight of the burns occurred in a housing project in an inner-city neighborhood on the west side of Chicago near the clinic. In 1995, a total of 3318 persons resided in the housing project. The housing project includes 15 buildings, 11 of which are heated by steam radiator systems operating at 180 F–230 F (82 C–110 C). Four buildings are heated by hot water radiator systems operating at 120 F (49 C). All eight burns to housing project tenants were in the section served by steam radiators.

Eight of the 10 children suffered partial thickness burns that were treated in the outpatient clinic. Burns were distributed among the leg/foot, head, and arm/hand. Two children were hospitalized for full-thickness burns. One was a 16-month-old child who touched an exposed steam radiator pipe, resulting in severe burns to the palm of her hand that required a skin graft. The other was a 7-month-old infant who fell out of bed and became wedged between the bed and the radiator, resulting in multiple burns to her left hand, left arm, left ear, and left side of the head that required treatment in a burn unit. Two other children (aged 10 months and 31 months) also were burned when they became trapped between a bed and a steam radiator.

After the investigation determined that the burns incurred by the children were associated with contact with uncovered radiators, each family was encouraged to contact the housing authority for proper repairs. In addition, physicians instructed parents about the proper location of beds or cribs in proximity to steam radiators. Details of the cases were sent to the housing authority in June 1994.

All 169 units in the two buildings where more than one child was burned were inspected beginning in August 1994; 133 (79%) of these units were missing radiator covers, insulation surrounding radiator pipes, or both. In addition, of the 104 housing units in these two buildings in which children aged <10 years resided, 89 (86%) were missing such radiator protection.

During November 1994–August 1995, the housing authority replaced or repaired needed radiator covers and pipe insulation in all units of the 11 project buildings served by steam radiators. One child came to the health center for treatment of a radiator burn while these repairs were being made. The child had been burned in a building served by steam radiators that had not yet been repaired. An evaluation of this intervention is planned.

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Home Radiator Burns — Continued

Editorial Note: The findings in this report underscore the potential effectiveness of a public health response to a specific local pattern of injury. Although childhood burns resulting from contact with wood-burning stoves (*4,5*), kerosene heaters (*6*), and floor furnaces (*7–9*) have been reported, this is the first description of burns related to radiators used for home heating.

The age distribution and hospital admission rate of the 10 children reported in Chicago are consistent with patterns of radiator burns reported for the United States (*3*). Of all emergency department visits for burns related to home radiators in the United States during 1993, 22% resulted in hospital admission, and 68% involved children aged 0–4 years. Among children aged 0–4 years who visited the emergency department for such an injury, 16% slept in a bed that was too close to a radiator (*3*).

Unprotected radiators and their pipes were directly related to injury risk for the children in this report. Building codes in Chicago require radiators to be covered in public places (e.g., churches, day-care facilities, and schools) but not in private or public housing. Steam radiator systems are found primarily in older buildings. The buildings served by steam radiators in the housing project in this report were constructed during the late 1950s, and the buildings served by hot water radiators were built during the 1960s.

Temperature is a critical factor in thermal injury. Contact with temperatures in the range of steam radiators can cause an instantaneous full-thickness burn of adult human skin. Children's skin is probably more susceptible than that of adults to thermal injury. In comparison, hot water radiators operate at a lower temperature than steam radiators and present a lower risk for thermal injury.

Risks for burns from home radiators can be reduced by keeping the unit covered and the pipes insulated. In addition, beds, couches, and chairs should be kept at a safe distance from radiators to avoid contact burn injury. Recognition of steam radiator burns in other communities may prompt investigations similar to that in Chicago and improvement of heating systems to prevent burn injury.

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Update: Influenza Activity — Worldwide, 1996

From October 1995 through August 1996, influenza activity occurred at moderate to severe levels worldwide. Epidemic activity in Europe, Asia, and North America was associated with influenza A(H1N1) and influenza A(H3N2) viruses. Influenza A(H1N1) viruses caused an epidemic in Japan and predominated in Canada, most regions of the United States, and a few countries in Europe. Influenza A(H3N2) viruses predominated in most European countries, China, and some regions of the United States. Influenza B viruses were isolated in association with sporadic cases throughout most of the world (*1,2*). This report summarizes influenza activity worldwide during March–August 1996, indicating that, during these months, influenza activity occurred at peak levels in the Southern Hemisphere.

Africa. During June, the first localized outbreak of influenza-like illness (ILI) associated with influenza A(H1N1) infections occurred among adult workers in Durban, South Africa. Influenza A(H3N2) viruses were isolated in Senegal in June and in Madagascar and South Africa in June and July.

Asia. During March–August, influenza A(H3N2) viruses predominated in Asia, but influenza A(H1N1) and influenza B viruses also were identified. In Korea during March and April, influenza A(H3N2) and influenza B viruses were isolated. From March through June, influenza A(H3N2), influenza A(H1N1), and influenza B viruses circulated in China. In southern China, outbreaks associated with influenza A(H3N2) viruses occurred in Guangzhou Province during March, April, and May; Guangxi Province during April and May; Hainan Province during May; and Fujian Province during May and June. In Hong Kong, the number of influenza viruses isolated peaked during March and April, then again during July and August; influenza A(H1N1) and influenza B viruses were isolated sporadically, but influenza A(H3N2) viruses were associated with outbreaks. From May through July, influenza A(H3N2) and influenza B viruses were isolated sporadically in Taiwan and Guam.

Europe. In March, several countries reported sporadic isolation of influenza A(H1N1) (Croatia, Germany, and the United Kingdom), influenza A(H3N2) (Germany and Iceland), and influenza B viruses (Austria, Czech Republic, France, Germany, Greece, Sweden, and Switzerland). Sporadic isolation of all three influenza viruses also was reported in Europe during the summer.

North America. Influenza activity in the United States increased during November and December 1995, peaked during mid-December through early January 1996, and declined thereafter with widespread* and regional activity last reported for the weeks ending March 2 (week 9) and April 20 (week 16), respectively. CDC received influenza B isolates collected during every month from March through July for antigenic characterization. During June and July, these viruses were associated with sporadic cases in Alaska, Hawaii, Ohio, Pennsylvania, and Texas. Influenza A(H3N2) viruses were collected during every month from March through August. These included influenza A(H3N2) isolates from a nursing home outbreak in Washington in which 31 (40%) of 77 residents and 29 (19%) of 150 staff members became ill during May 31–June 24; two residents died. Influenza A(H3N2) viruses also were isolated from residents and

*Levels of activity are 1) *no activity*; 2) *sporadic*—sporadically occurring ILI or culture-confirmed influenza, with no outbreaks detected; 3) *regional*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of <50% of the state's total population; and 4) *widespread*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of ≥50% of the state's total population.

Influenza Activity — Continued

staff in association with an outbreak of ILI in a nursing home in Hawaii; 70 (38%) of 183 residents and 36 (29%) of 125 staff became ill during July 17–30. In addition, from July 1 through August 22, a total of 14 (19%) of 74 respiratory specimens collected from military personnel and their family members at Tripler Army Medical Center in Hawaii were positive for influenza type A. All viruses subtyped were influenza A(H3N2). Sporadic influenza A(H3N2) isolates were identified in Alaska during July and in Wisconsin during August and September.

In Canada, influenza A and influenza B viruses were isolated from sporadic cases throughout May and June. Only one isolate of influenza B virus was reported in July. In August, Ontario reported isolation of influenza A(H1N1) and influenza A(H3N2) viruses.

Central and South America. Chile reported isolation of influenza A viruses in the northern, central, and southern regions during June. During May and June, outbreaks of ILI associated with influenza A(H1N1) and influenza A(H3N2) occurred in Santiago and Valparaiso. Brazil reported outbreaks of influenza A(H3N2) viruses during April and June and influenza A(H1N1) viruses during May and June.

Oceania. Epidemic level activity was associated with influenza A(H3N2) viruses while influenza A(H1N1) and influenza B viruses circulated at low levels. In Australia, influenza A(H3N2) virus activity increased sharply in June and peaked in July at a level substantially higher than reported in 1995. In August, influenza activity declined in most regions of Australia, but Queensland reported increased activity and the Northern Territory reported severe outbreaks. In New Zealand, seasonal activity began in May with school outbreaks of influenza type A(H3N2). The number of influenza isolates and consultation rates for ILI increased rapidly and peaked in June and early July. The 1996 influenza type A(H3N2) epidemic reported from New Zealand was the largest since the revision of their surveillance program in 1990 (*3*).

Characterization of influenza virus isolates. Influenza A(H1N1) viruses predominated in most parts of the United States during the 1995–96 influenza season, but influenza A(H3N2) and influenza B viruses accounted for 35% and 15%, respectively, of isolates reported by the World Health Organization Collaborating Laboratories from October 1, 1995, through May 18, 1996. From October 1, 1995, through September 6, 1996, a total of 1016 influenza isolates collected worldwide were antigenically characterized by the World Health Organization Collaborating Center for Surveillance, Epidemiology, and Control of Influenza at CDC. Of these, 566 (56%) were from North America; 130 (13%), from Europe; 263 (26%), from Asia; and 57 (6%), from South America and Oceania. Of the viruses subtyped, 457 (45%) were influenza A(H3N2), 348 (34%) were influenza A(H1N1), and 211 (21%) were influenza B. Of the 457 influenza A(H3N2) isolates characterized, 306 (67%) were antigenically related to A/Johannesburg/33/94, the 1995–96 vaccine strain, and 151 (33%) were more closely related to A/Wuhan/359/95, the A(H3N2) component of the 1996–97 influenza vaccine. The proportion of A/Wuhan/359/95(H3N2)-like viruses have increased since January 1996. Of the 211 influenza B viruses, 207 (98%) were similar to B/Beijing/184/93, the current vaccine strain. Four (2%) of the influenza B viruses were antigenically related to B/Victoria/02/87. B/Victoria/02/87-like viruses circulated in 1988–89 and since then have been isolated sporadically only in China and Hong Kong. Of the 348 influenza A(H1N1) viruses, 318 (91%) were A/Texas/36/91-like or related to the antigenically similar A/Taiwan/01/86-like viruses, and 30 (9%) were antigenically similar to a recently

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identified variant that has been isolated only in China and Hong Kong. The influenza A(H1N1) component of the 1996–97 vaccine is A/Texas/36/91.

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Editorial Note: In the United States, sporadic cases of influenza are common during the summer, but outbreaks of influenza, such as those observed in Washington and Hawaii during June and July, are not common. Although specific patterns of influenza activity and the time and extent of virus circulation cannot be predicted with certainty, the recent worldwide pattern of influenza suggests that all three influenza virus strains—type A(H3N2), type A(H1N1), and type B—will circulate during the 1996–97 influenza season in the United States.

The influenza vaccine is updated annually to include viruses antigenically similar to the strains of the three distinct groups of influenza viruses that are in worldwide circulation. The influenza vaccine for the 1996–97 influenza season contains A/Texas/36/91-like (H1N1), A/Wuhan/359/95-like (H3N2), and B/Beijing/184/93-like antigens (*2,4*). For the A/Wuhan/359/95-like and B/Beijing/184/93-like antigens, U.S. manufacturers will use the antigenically equivalent strains A/Nanchang/933/95(H3N2) and B/Harbin/07/94 viruses, respectively, because of their growth properties. Since March 1996, most influenza viruses isolated worldwide have been antigenically similar to the vaccine strains.

Vaccination against influenza is recommended by the Advisory Committee on Immunization Practices for persons aged ≥65 years; persons who reside in nursing homes or chronic-care facilities; persons with chronic cardiovascular or pulmonary disorders, including children with asthma; persons who required medical follow-up or hospitalization during the previous year because of diabetes or other chronic metabolic diseases, renal dysfunction, hemoglobinopathies, or immunosuppression; and children and teenagers (aged 6 months–18 years) receiving long-term aspirin therapy and who therefore may be at risk for developing Reye syndrome after influenza. Vaccination also is recommended for health-care workers and other persons, including household members, in frequent contact with persons at high-risk for influenza-related complications. Pregnant women who will be in the third trimester during the influenza season may be at increased risk for medical complications following influenza infection and should consult with their health-care providers about receiving the vaccine. Influenza vaccine also can be administered to persons who want to reduce the likelihood of acquiring influenza (*4*).

The optimal time for organized influenza vaccination campaigns is October through mid-November, but beginning in September, health-care providers should offer influenza vaccine to persons at high risk who are seen for routine care or as a result of hospitalization. Health-care providers should continue to offer influenza vaccine to high-risk persons until and even after influenza activity has been documented in the community.

Although vaccination against influenza is the most effective means of reducing the impact of influenza, antiviral agents provide a useful adjunct. Antiviral agents avail-

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able for the prophylaxis or treatment of influenza type A infection are amantadine hydrochloride and rimantadine hydrochloride. Neither drug is effective against influenza type B viruses. Use of antivirals may be considered in certain situations including 1) as a control measure when influenza outbreaks occur in institutions—both for treatment of ill persons and as prophylaxis for others; 2) as short-term prophylaxis for high-risk persons who are vaccinated after influenza activity has begun and who need protection for the 2-week period during which immunity is developing; 3) as prophylaxis during peak influenza activity for persons for whom vaccine is contraindicated or for immunocompromised persons who may not produce protective levels of antibody in response to vaccination; and 4) as prophylaxis for unvaccinated health-care workers and household contacts of high-risk persons either during peak influenza activity or until immunity develops after vaccination. Because amantadine and rimantadine are effective only against influenza type A, use of rapid diagnostic testing for influenza type A and close monitoring of local influenza surveillance reports may assist health-care providers in making treatment decisions for patients with ILI.

Information about influenza surveillance is available through the CDC Voice Information System (influenza update) by telephone ([404] 332-4555) or fax ([404] 332-4565) (document no. 361100) or through the CDC Information Service on the Public Health Network electronic bulletin board. From October through May, the information is updated weekly. Periodic updates about influenza are published in *MMWR* and information about local influenza activity is available through county and state health departments.

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Poliomyelitis Outbreak — Albania, 1996

During April 17–September 16, 1996, an ongoing outbreak of paralytic poliomyelitis in Albania resulted in 66 cases of acute flaccid paralysis (AFP), including seven (11%) deaths. Wild poliovirus type 1 was isolated from seven cases.

The first case-patient, a 12-month-old child, had onset of paralysis on April 17; ages of AFP patients ranged from 4 months to 46 years (median age: 20–24 years). Of the reported AFP cases, 46 (70%) occurred among persons aged 10–30 years, and 13 (20%) occurred among persons aged ≥30 years. Seven cases occurred among children aged 0–9 years; five (8%) were among children aged <5 years. Cases have been reported from 18 of 37 districts, primarily in the northern and central parts of the country; no cases have been reported from the southernmost districts.

National Immunization Days (NIDs) were successfully completed on April 8 and May 17, during which reported coverage with oral poliovirus vaccine (OPV) was

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>97% among children aged <5 years, the targeted age group. Albania's Ministry of Health is organizing a mass vaccination campaign with OPV for children and adults (aged 0–50 years) to control the outbreak.

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Editorial Note: Preliminary results of the outbreak investigation suggest that factors contributing to this outbreak include 1) problems with the delivery of routine vaccination services before 1993, 2) an increase in contacts with persons from polio-endemic countries since 1991, and 3) sanitation problems resulting from recent large-scale movement of segments of the Albanian population to urban areas. The relatively low incidence among children aged <5 years may be a result of the recent NIDs and improvements in the cold chain for routine vaccination services since 1993. The high case-fatality rate may be due to the high proportion of cases among older children and adults—who are known to be at higher risk for bulbar paralysis—and may be aggravated by delays in seeking medical care.

Travelers to Albania who have received a primary series of polio vaccine should receive a booster dose before departure. Travelers who are inadequately vaccinated against polio or whose past vaccination history is uncertain should contact their physician to discuss polio vaccination options before leaving for Albania.

Contraceptive Method and Condom Use Among Women at Risk for HIV Infection and Other Sexually Transmitted Diseases — Selected U.S. Sites, 1993–1994

A primary strategy for decreasing the spread of human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs) is to increase the rate of condom use among at-risk persons, and an important approach for reducing unintended pregnancies is to increase the use of effective contraception. Some women are at risk for both STDs and unintended pregnancy and require a highly effective strategy for protection against both risks. To assess the association between condom use at last intercourse and use of specific methods to prevent pregnancy among women at risk for HIV infection and other STDs, project investigators analyzed data from the Prevention of HIV in Women and Infants Demonstration Project. This report presents the findings of the analysis, which indicate that many women who were potentially well protected against pregnancy were underprotected against STDs.*

The demonstration project is an intervention research study begun in 1993. For the baseline assessment, women were interviewed about reproductive health and STDs in eight sites (Oakland [one site] and San Francisco [two sites], California; Portland, Oregon [one site]; and Philadelphia [two sites] and Pittsburgh [two sites], Pennsylva-

*Single copies of this report will be available until September 26, 1997, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231 or (301) 217-0023.

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nia). Women were recruited during 1993 and 1994 from settings frequented by women at risk for HIV infection and other STDs (e.g., residential, business, and outdoor settings and social- and health-service organizations). Women aged 15–34 years who reported having vaginal intercourse during the previous 30 days with either a main partner and/or casual partner(s) (n=3326) were asked about the method they used to prevent pregnancy, type of partner, HIV-related risk behaviors, and condom use at last vaginal intercourse with a main and/or casual partner(s). Interviewers asked women which of three commonly recommended methods of contraception they used to prevent pregnancy: 1) condoms only (including condoms plus spermicides); 2) hormonal contraception, specifically oral contraceptives, levonorgestrel implants (Norplant®†), or injectable medroxyprogesterone acetate (Depo-Provera®); and 3) surgical sterilization. Women included in this analysis reported 1) using only one of these methods for birth control, 2) not being HIV positive, 3) having ever (lifetime) had her partner use a condom for pregnancy prevention, and 4) having one or more risk factors for HIV infection. For women who had sex with a main partner during the previous 30 days, risk factors for HIV infection included having more than one sex partner during the previous 6 months; injecting drugs during the previous year; or having a main sex partner who injects drugs, has sex with others, or is HIV positive. For women with casual partners, the risk factors for HIV infection consisted of having vaginal sex with a casual partner during the previous 30 days.

Of the 3326 women interviewed, 1676 met the risk factor criteria; 1083 of those used one of the specified methods to prevent pregnancy. Twelve women who were HIV positive and 119 women who had never had a partner use condoms for birth control were excluded, yielding a sample of 952 women.

Among the 952 women, the median age was 26 years; 740 (78%) were black; 391 (41%) had less than a high school education; 684 (72%) received at least some of their income from welfare; and 627 (66%) lived in a household with children. In addition, 564 (59%) of the women reported having had sex with a main partner, and 580 (61%) reported having had sex with a casual partner during the previous 30 days.

Logistic regression analyses were conducted to test the strength of association between method used to prevent pregnancy and condom use at last intercourse with either a main or casual partner. Women who had vaginal intercourse with both a main partner and a casual partner were included in both analyses. Contraceptive method was the primary independent variable; age, education level, race, ethnicity, and site were controlled for in each analysis.

Of the 555 women with main partners for whom complete data were available, 309 (56%) reported not using condoms at last intercourse with their main partner; of 569 women with a casual partner for whom complete data were available, 163 (29%) reported not using condoms at last intercourse with their casual partner. Among women whose contraceptive method was condoms, 108 (39%) of 277 had not used a condom at last intercourse with their main partner, and 73 (22%) of 336 had not used a condom at last intercourse with their casual partner. Among women who used hormonal contraception, 74 (70%) of 105 had not used a condom at last intercourse with their main partner, and 32 (42%) of 76 had not used a condom at last intercourse with their casual partner. Among women who were surgically sterilized, 127 (73%) of 173

†Use of trade names and commercial sources is for identification only and does not imply endorsement by the Public Health Service or the U.S. Department of Health and Human Services.

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had not used a condom at last intercourse with their main partner and 58 (37%) of 157 had not used a condom at last intercourse with their casual partner. Compared with women reporting condoms as their method of pregnancy prevention, women using hormonal contraception were 4.2 (95% confidence interval [CI]=2.5–7.0) times more likely to report not using condoms at last intercourse with their main partner, and surgically sterile women were 4.1 (95% CI=2.5–6.6) times more likely to report not using condoms with their main partner. Compared with women reporting condoms as their method of pregnancy prevention, women using hormonal contraception were 2.2 (95% CI=1.3–3.9) times more likely to report not using condoms at last intercourse with their casual partner, and surgically sterile women were 1.8 (95% CI=1.1–3.0) times more likely to report not using condoms with their casual partner.

At two sites, women were asked additional questions about their understanding of the effectiveness of various contraceptive methods in preventing STDs. Of the 174 women who responded to these questions, 27 (16%) said birth control pills were somewhat or very effective, 13 (8%) said Norplant® was somewhat or very effective, and 17 (10%) said surgical sterilization was somewhat or very effective in preventing STDs.

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Editorial Note: The findings in this report are consistent with previous findings from studies of condom use among sterilized women (*1,2*) that suggest condom use is lower among women who believe they are effectively preventing pregnancy without condoms. Differences in reported condom use in the categories compared in this sample may be related to women's perceptions of the relative importance of preventing pregnancy compared with preventing disease. Women who use contraceptive methods other than latex condoms may be less motivated to use an additional contraceptive method to protect themselves from disease, may have more difficulty persuading a partner that a condom is needed, or may incorrectly believe that those contraceptive methods provide protection from disease (*3*). To develop effective disease-prevention messages, better understanding is needed of why women at risk for HIV infection who are using contraceptive methods other than condoms do not use condoms for disease prevention.

Of the women interviewed in this study, more than half reported not using a condom at last intercourse with a main partner, and one third reported not using a condom at last intercourse with a casual partner. The failure to use condoms, particularly with main partners, leaves these women vulnerable to STDs, including HIV infection. Health-care practitioners should emphasize that latex condoms are the only contraceptive proven effective against HIV infection and that, when used consistently and correctly, they are highly effective for both disease and pregnancy prevention (*4,5*).

Findings from this study also indicate that condoms are being used in conjunction with other contraceptive methods by substantial numbers of women, especially with casual partners. A dual-method approach (e.g., hormonal contraception plus condoms) for pregnancy and disease prevention may be feasible for some women at risk for both unintended pregnancy and STDs. Some women at risk, however, may find

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that using the single method of latex condoms consistently and correctly for the dual purpose of pregnancy and disease prevention is more acceptable. Additional strategies are needed to protect more women at risk for both unintended pregnancy and disease.

The findings of this report are subject to at least two limitations. First, because the study sample was not representative of all women in the United States or all women at risk for HIV infection and other STDs, findings cannot be generalized for all women. Second, it cannot be determined whether failure to use condoms resulted from use of other contraceptive methods or other contraceptive methods were used because of the women's reluctance to have their partners use condoms.

Practitioners should recognize that women at risk for STDs who are not using condoms for pregnancy prevention may not use condoms for prevention of HIV infection and other STDs. Special efforts are needed to counsel these women about the necessity of condom use to prevent HIV infection and other STDs.

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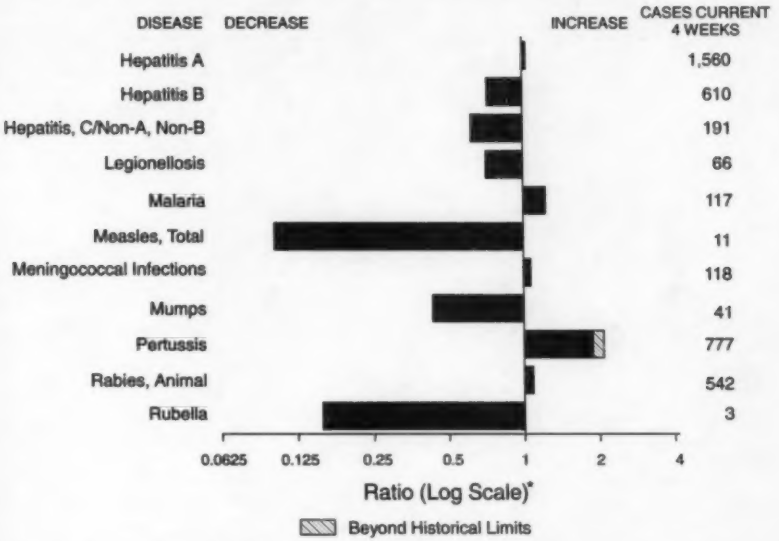
5. CDC. Update: barrier protection against HIV infection and other sexually transmitted diseases. MMWR 1993;42:589–91,597.

FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending September 21, 1996, with historical data — United States



*Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — provisional cases of selected notifiable diseases, United States, cumulative, week ending September 21, 1996 (38th Week)

	Cum. 1996		Cum. 1996
Anthrax	-	HIV infection, pediatric*§	195
Brucellosis	60	Plague	1
Cholera	3	Poliomyelitis, paralytic¶	-
Congenital rubella syndrome	1	Psittacosis	28
Cryptosporidiosis*	1,479	Rabies, human	1
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	510
Encephalitis: California*	51	Streptococcal toxic-shock syndrome*	14
eastern equine*	1	Syphilis, congenital**	225
St. Louis*	-	Tetanus	20
western equine*	-	Toxic-shock syndrome	102
Hansen Disease	75	Trichinosis	15
Hantavirus pulmonary syndrome*†	11	Typhoid fever	255

-: no reported cases
*Not notifiable in all states.
†Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§Updated monthly to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention (NCHSTP), last update August 27, 1996.
¶Three suspected cases of polio with onset in 1996 has been reported to date.
**Updated quarterly from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending September 21, 1996, and September 23, 1995 (38th Week)

Reporting Area	AIDS* Cum. 1996	AIDS* Cum. 1995	Chlamydia Cum. 1996	*Escherichia coli* O157:H7 NETSS† Cum. 1996	*Escherichia coli* O157:H7 PHLIS§ Cum. 1996	Gonorrhea Cum. 1996	Gonorrhea Cum. 1995	Hepatitis C/NA,NB Cum. 1996	Hepatitis C/NA,NB Cum. 1995	Legionellosis Cum. 1996	Legionellosis Cum. 1995
UNITED STATES	45,416	53,042	263,952	1,820	960	205,895	285,856	2,427	2,851	625	866
NEW ENGLAND	1,849	2,603	12,149	256	55	5,176	5,535	82	95	35	21
Maine	31	75	674	21	-	45	67	-	-	2	5
N.H.	58	75	397	31	30	80	83	7	12	2	1
Vt.	14	21	U	18	15	42	45	29	9	3	-
Mass.	873	1,121	4,796	125	10	1,616	1,958	40	69	19	12
R.I.	123	160	1,423	10	-	381	380	6	5	9	3
Conn.	750	1,131	4,859	50	-	3,012	3,002	-	-	N	N
MID. ATLANTIC	12,627	14,353	31,517	166	38	23,552	32,291	211	328	158	148
Upstate N.Y.	1,672	1,727	N	113	12	4,628	6,777	167	158	56	39
N.Y. City	7,052	7,607	15,097	10	-	7,762	12,943	1	1	6	5
N.J.	2,402	3,276	3,286	43	5	3,649	3,227	-	136	12	21
Pa.	1,501	1,743	13,134	N	21	7,513	9,344	43	33	84	83
E.N. CENTRAL	3,616	4,036	45,596	444	284	31,209	56,887	334	237	165	261
Ohio	810	847	14,005	120	57	10,367	17,625	26	8	72	123
Ind.	462	380	7,397	62	39	4,811	6,659	7	2	36	60
Ill.	1,579	1,725	17,889	187	84	13,000	14,793	52	68	9	24
Mich.	570	817	U	75	58	U	12,905	249	159	34	24
Wis.	195	267	6,305	N	48	3,031	4,905	-	-	14	30
W.N. CENTRAL	1,060	1,199	20,370	395	237	8,972	14,939	96	64	34	59
Minn.	189	243	2,702	163	153	U	2,176	1	2	3	4
Iowa	69	70	2,866	90	55	741	1,151	45	12	9	18
Mo.	541	559	8,935	49	-	5,943	8,472	31	18	6	13
N. Dak.	10	4	2	14	14	-	23	-	5	-	3
S. Dak.	9	14	724	13	-	103	158	-	1	2	1
Nebr.	74	80	1,920	37	3	718	862	5	14	11	13
Kans.	168	229	3,221	29	12	1,467	2,097	14	12	3	7
S. ATLANTIC	11,216	13,311	39,803	102	53	70,160	79,367	193	174	104	138
Del.	215	239	1,148	1	1	1,066	1,620	1	-	10	2
Md.	1,324	2,033	4,978	N	8	10,484	9,497	1	7	20	24
D.C.	799	755	N	-	-	3,209	3,267	-	-	8	4
Va.	795	1,072	8,067	N	23	6,696	8,171	12	13	13	18
W. Va.	83	84	1	N	2	389	497	9	41	1	3
N.C.	603	816	-	28	12	13,396	17,720	36	45	7	30
S.C.	586	726	-	8	7	8,275	9,125	21	16	4	28
Ga.	1,651	1,644	8,109	29	-	13,317	14,442	U	15	3	14
Fla.	5,160	5,942	17,300	26	-	13,348	15,028	113	37	38	15
E.S. CENTRAL	1,563	1,712	21,664	42	38	23,185	29,727	431	768	37	49
Ky.	272	220	4,790	9	5	3,036	3,448	23	24	4	9
Tenn.	580	665	9,886	19	30	8,593	10,065	328	742	18	24
Ala.	431	482	6,125	9	3	9,767	12,460	4	2	3	6
Miss.	280	345	U	5	-	1,789	3,754	76	U	12	10
W.S. CENTRAL	4,562	4,624	31,017	38	12	23,262	40,187	347	213	18	17
Ark.	186	209	-	11	3	2,555	3,947	7	5	2	5
La.	1,046	746	5,352	5	4	5,772	8,220	152	132	1	2
Okla.	189	206	5,551	8	1	3,560	4,042	69	34	5	4
Tex.	3,141	3,463	20,114	14	4	11,375	23,978	119	42	10	6
MOUNTAIN	1,325	1,627	11,995	148	71	5,215	6,973	426	342	32	89
Mont.	23	17	-	15	-	24	51	14	11	1	4
Idaho	29	38	1,130	28	10	81	108	92	43	-	2
Wyo.	3	12	420	10	2	27	42	141	135	3	8
Colo.	362	522	-	56	31	1,077	2,137	41	53	7	33
N. Mex.	118	137	2,705	8	-	576	772	54	39	1	4
Ariz.	370	458	5,001	N	20	2,661	2,710	53	34	16	9
Utah	127	112	1,148	19	-	226	182	22	11	2	12
Nev.	293	331	1,591	12	8	543	971	9	16	2	17
PACIFIC	7,597	9,577	50,021	230	172	15,164	19,950	307	630	42	84
Wash.	508	710	6,763	73	71	1,485	1,953	43	157	5	20
Oreg.	339	324	U	63	36	442	570	6	33	-	-
Calif.	6,594	8,293	37,823	91	56	12,672	16,485	107	405	33	59
Alaska	23	60	848	3	2	304	501	3	1	1	-
Hawaii	133	190	886	N	7	261	441	148	34	3	5
Guam	4	-	168	N	-	31	83	1	5	2	1
P.R.	1,524	1,904	N	13	U	254	426	77	178	-	-
V.I.	17	27	N	N	U	-	-	-	-	-	-
Amer. Samoa	-	-	-	N	U	-	19	-	-	-	-
C.N.M.I.	1	-	N	N	U	11	45	-	5	-	-

N: Not notifiable U: Unavailable -: no reported cases C.N.M.I.: Commonwealth of Northern Mariana Islands

*Updated monthly to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, last update August 27, 1996.
†National Electronic Telecommunications System for Surveillance.
§Public Health Laboratory Information System.

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending September 21, 1996, and September 23, 1995 (38th Week)

Reporting Area	Lyme Disease		Malaria		Meningococcal Disease		Syphilis (Primary & Secondary)		Tuberculosis		Rabies, Animal	
	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995
UNITED STATES	8,949	8,171	1,027	937	2,375	2,257	7,742	12,077	13,470	14,975	4,441	5,743
NEW ENGLAND	3,117	1,617	40	38	100	105	124	272	297	370	538	1,156
Maine	31	16	7	5	12	8	-	2	4	11	75	21
N.H.	31	19	2	1	3	18	1	1	9	15	48	117
Vt.	15	8	2	1	3	7	-	-	1	2	118	140
Mass.	217	95	13	12	40	36	60	46	152	204	86	352
R.I.	410	272	6	4	10	5	1	3	27	37	33	254
Conn.	2,413	1,207	10	15	32	31	62	220	104	101	178	272
MID. ATLANTIC	4,934	5,308	253	261	205	282	307	618	2,446	3,167	531	1,492
Upstate N.Y.	2,782	2,664	63	51	65	76	51	63	296	371	265	876
N.Y. City	199	350	126	141	31	39	94	267	1,239	1,800	-	-
N.J.	572	1,425	49	51	53	70	77	129	521	543	105	266
Pa.	1,381	869	15	18	56	97	85	159	390	453	161	350
E.N. CENTRAL	58	354	103	125	332	320	949	2,065	1,491	1,428	77	82
Ohio	36	23	13	9	124	91	340	644	214	197	10	10
Ind.	20	14	14	15	53	47	163	241	133	134	5	14
Ill.	2	16	35	65	88	86	320	814	793	730	19	13
Mich.	-	5	30	15	35	57	U	210	275	300	30	33
Wis.	U	296	11	21	32	39	126	156	76	67	13	12
W.N. CENTRAL	109	138	39	19	195	138	277	594	335	439	408	290
Minn.	39	68	17	3	25	23	51	34	78	107	21	23
Iowa	18	10	2	2	39	25	15	37	44	48	185	103
Mo.	22	37	9	6	81	52	179	486	145	163	16	25
N. Dak.	-	-	1	1	3	1	-	-	6	3	53	24
S. Dak.	-	-	-	2	9	5	-	-	15	19	103	74
Nebr.	2	4	3	3	17	12	12	11	13	20	3	5
Kans.	28	19	7	2	21	20	20	26	34	79	27	36
S. ATLANTIC	514	525	224	177	487	366	2,757	3,015	2,578	2,604	2,064	1,543
Del.	78	37	3	1	2	6	33	10	20	44	59	74
Md.	296	350	61	50	54	31	475	335	217	296	464	311
D.C.	3	2	7	15	10	4	109	81	102	77	9	11
Va.	39	43	33	40	45	50	300	469	201	167	444	308
W. Va.	11	21	3	2	11	8	3	9	45	56	76	93
N.C.	58	44	21	15	62	64	773	838	361	320	538	367
S.C.	4	16	9	1	45	47	298	446	257	226	69	100
Ga.	1	9	23	23	114	72	479	551	466	478	222	209
Fla.	24	3	64	30	144	84	287	276	909	940	183	70
E.S. CENTRAL	52	53	24	20	136	159	1,722	2,502	957	1,054	161	218
Ky.	13	12	3	2	21	37	102	135	175	226	34	22
Tenn.	17	21	12	7	16	61	620	651	297	331	80	74
Ala.	6	7	3	8	59	31	414	496	320	305	64	115
Miss.	16	13	6	3	40	30	586	1,220	165	192	3	7
W.S. CENTRAL	87	83	23	38	281	270	1,143	2,409	1,647	1,977	286	526
Ark.	21	7	-	2	32	26	121	364	133	157	15	33
La.	1	4	5	4	47	39	403	764	59	196	13	24
Okla.	14	35	-	1	29	28	142	147	134	146	24	28
Tex.	51	37	18	31	173	177	477	1,134	1,321	1,478	U	441
MOUNTAIN	6	7	47	47	134	164	109	169	424	456	118	137
Mont.	-	-	6	3	4	2	-	4	14	10	20	39
Idaho	-	-	-	1	19	8	4	-	7	11	-	1
Wyo.	2	3	7	-	3	7	2	-	6	2	23	23
Colo.	-	-	20	22	29	42	23	95	54	38	39	9
N. Mex.	1	1	2	4	22	30	1	5	55	60	5	5
Ariz.	-	-	6	7	35	47	68	32	177	228	25	39
Utah	1	1	4	5	12	14	2	4	39	24	3	13
Nev.	2	2	2	5	10	14	11	29	72	83	3	8
PACIFIC	72	86	274	212	505	453	354	433	3,295	3,480	258	299
Wash.	13	10	19	16	77	73	5	11	186	201	6	11
Oreg.	11	13	17	13	88	83	10	19	76	88	1	1
Calif.	47	63	228	171	330	286	338	402	2,853	3,008	243	280
Alaska	-	-	3	2	6	7	-	1	49	52	8	7
Hawaii	1	-	7	10	4	4	1	-	131	131	-	-
Guam	-	-	-	1	1	2	3	8	35	83	-	-
P.R.	-	-	-	1	5	19	101	205	63	120	36	35
V.I.	-	-	-	2	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	3	-	-
C.N.M.I.	-	-	-	1	-	-	1	6	-	30	-	-

N: Not notifiable U: Unavailable -: no reported cases

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending September 21, 1996, and September 23, 1995 (38th Week)

Reporting Area	*H. influenzae*, invasive		Hepatitis (viral), by type				Measles (Rubeola)			
			A		B		Indigenous		Imported†	
	Cum. 1996*	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	1996	Cum. 1996	1996	Cum. 1996
UNITED STATES	804	848	19,438	21,213	6,887	7,229	-	398	-	42
NEW ENGLAND	22	32	267	202	145	174	-	10	-	4
Maine	-	3	15	22	2	7	-	-	-	-
N.H.	8	8	12	9	10	18	-	-	-	-
Vt.	1	2	6	5	10	5	-	1	-	1
Mass.	11	10	140	82	49	65	-	8	-	3
R.I.	2	3	13	25	9	8	-	-	-	-
Conn.	-	6	81	59	65	71	-	1	-	-
MID. ATLANTIC	139	123	1,181	1,300	999	1,032	-	23	-	5
Upstate N.Y.	41	34	318	314	255	274	-	-	-	-
N.Y. City	28	29	425	632	451	321	-	9	-	3
N.J.	45	15	250	186	185	281	-	3	-	-
Pa.	25	45	188	168	108	156	-	11	-	2
E.N. CENTRAL	129	144	1,623	2,389	723	817	-	5	-	7
Ohio	77	73	590	1,326	98	84	-	2	-	3
Ind.	8	18	232	134	119	155	-	-	-	-
Ill.	32	35	359	496	176	212	-	2	-	1
Mich.	7	16	317	275	281	308	-	-	-	3
Wis.	5	2	125	158	49	58	-	1	-	-
W.N. CENTRAL	41	63	1,722	1,443	345	471	-	21	-	2
Minn.	25	34	95	144	41	43	-	18	-	2
Iowa	5	3	273	63	74	35	-	-	-	-
Mo.	7	19	821	1,040	165	329	-	4	-	-
N. Dak.	-	-	84	22	2	4	-	-	-	-
S. Dak.	1	1	41	39	6	2	-	-	-	-
Nebr.	1	3	162	38	31	24	-	-	-	-
Kans.	2	3	246	97	26	34	-	1	-	-
S. ATLANTIC	170	166	929	809	1,083	930	-	6	-	9
Del.	2	-	13	9	7	6	-	1	-	-
Md.	50	55	159	158	222	189	-	2	-	2
D.C.	5	-	28	19	29	15	-	-	-	-
Va.	7	22	125	155	103	86	-	-	-	3
W. Va.	7	7	13	17	20	40	-	-	-	-
N.C.	22	25	106	85	265	224	-	3	-	1
S.C.	4	1	43	36	64	37	-	-	-	-
Ga.	55	53	90	51	10	62	-	-	-	2
Fla.	18	5	352	279	363	271	-	-	-	1
E.S. CENTRAL	22	8	1,018	1,423	641	649	-	2	-	-
Ky.	4	2	34	36	41	57	-	-	-	-
Tenn.	9	-	679	1,193	397	512	-	2	-	-
Ala.	8	5	143	65	49	80	-	-	-	-
Miss.	1	1	162	129	154	U	U	-	U	-
W.S. CENTRAL	31	53	4,077	2,991	912	985	-	26	-	2
Ark.	-	5	371	409	59	46	-	-	-	-
La.	3	1	116	93	88	154	-	-	-	-
Okla.	25	20	1,720	752	59	126	-	-	-	-
Tex.	3	27	1,870	1,737	706	639	-	26	-	2
MOUNTAIN	78	92	3,118	3,023	787	610	-	152	-	5
Mont.	-	-	91	94	9	19	-	-	-	-
Idaho	1	2	165	248	74	70	-	1	-	-
Wyo.	35	5	27	86	35	17	-	1	-	-
Colo.	11	14	339	387	102	89	-	4	-	3
N. Mex.	9	12	292	628	269	233	U	16	U	-
Ariz.	9	22	1,268	841	189	91	-	8	-	-
Utah	7	9	747	556	74	50	-	117	-	2
Nev.	6	28	189	183	35	41	-	5	-	-
PACIFIC	172	165	5,503	7,633	1,252	1,561	-	153	-	8
Wash.	2	8	359	626	73	141	-	51	-	-
Oreg.	22	22	633	2,010	51	94	-	4	-	-
Calif.	144	130	4,425	4,827	1,105	1,323	-	34	-	5
Alaska	2	1	32	35	12	10	-	63	-	-
Hawaii	2	4	55	135	11	13	-	1	-	3
Guam	-	-	2	7	-	4	U	-	U	-
P.R.	1	3	82	79	262	471	-	7	-	-
V.I.	-	-	-	6	-	14	U	-	U	-
Amer. Samoa	-	-	-	6	-	-	U	-	U	-
C.N.M.I.	10	11	1	23	5	17	U	-	U	-

N: Not notifiable U: Unavailable -: no reported cases

*Of 187 cases among children aged <5 years, serotype was reported for 42 and of those, 12 were type b.

†For imported measles, cases include only those resulting from importation from other countries.

TABLE III. (Cont'd.) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending September 21, 1996, and September 23, 1995 (38th Week)

Reporting Area	Measles (Rubeola), cont'd. Total		Mumps			Pertussis			Rubella		
	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995
UNITED STATES	440	269	12	473	626	199	3,569	3,015	-	197	106
NEW ENGLAND	14	8	-	1	11	34	720	395	-	25	44
Maine	-	-	-	-	4	-	20	25	-	-	-
N.H.	-	-	-	-	1	-	69	30	-	-	1
Vt.	2	-	-	-	-	3	61	62	-	2	-
Mass.	11	2	-	1	2	31	522	263	-	20	7
R.I.	-	5	-	-	1	-	25	2	-	-	-
Conn.	1	1	-	-	3	-	23	13	-	3	36
MID. ATLANTIC	28	12	2	62	95	23	291	256	-	9	13
Upstate N.Y.	-	1	-	19	24	17	161	116	-	4	3
N.Y. City	12	5	-	14	13	-	25	37	-	3	8
N.J.	3	6	-	2	16	-	11	16	-	2	2
Pa.	13	-	2	27	42	6	94	87	-	-	-
E.N. CENTRAL	12	14	1	84	107	35	379	352	-	3	3
Ohio	5	1	1	39	32	26	192	107	-	-	-
Ind.	-	-	-	6	7	2	36	24	-	-	-
Ill.	3	2	-	18	32	6	115	68	-	1	-
Mich.	3	5	-	20	36	1	31	57	-	2	3
Wis.	1	6	-	1	-	-	5	96	-	-	-
W.N. CENTRAL	23	2	-	13	38	14	239	191	-	1	-
Minn.	18	-	-	5	2	13	185	86	-	-	-
Iowa	-	-	-	1	9	1	11	7	-	1	-
Mo.	4	1	-	4	22	-	28	50	-	-	-
N. Dak.	-	-	-	2	1	-	1	8	-	-	-
S. Dak.	-	-	-	-	-	-	4	11	-	-	-
Nebr.	-	-	-	-	4	-	6	8	-	-	-
Kans.	1	1	-	1	-	-	4	21	-	-	-
S. ATLANTIC	15	11	1	82	92	16	428	240	-	91	9
Del.	1	-	-	-	-	1	12	10	-	-	-
Md.	4	1	1	22	28	6	153	32	-	-	1
D.C.	-	-	-	-	-	-	-	5	-	1	-
Va.	3	-	-	12	19	-	55	15	-	2	-
W. Va.	-	-	-	-	-	-	2	-	-	-	-
N.C.	4	-	-	19	16	4	79	84	-	77	1
S.C.	-	-	-	5	9	2	31	20	-	1	-
Ga.	2	2	-	3	6	-	17	19	-	-	-
Fla.	1	8	-	21	14	3	79	55	-	10	7
E.S. CENTRAL	2	-	2	21	9	3	71	260	-	2	1
Ky.	-	-	-	-	-	-	26	18	-	-	-
Tenn.	2	-	2	3	2	2	19	205	-	-	1
Ala.	-	-	-	3	4	1	18	35	-	2	-
Miss.	-	-	U	15	3	U	8	2	N	N	N
W.S. CENTRAL	28	24	2	27	41	7	87	242	-	3	7
Ark.	-	2	-	2	7	-	9	31	-	-	-
La.	-	18	-	12	9	-	7	14	-	1	-
Okla.	-	-	-	-	-	-	8	27	-	-	-
Tex.	28	4	2	13	25	7	63	170	-	2	7
MOUNTAIN	157	68	-	22	26	7	317	471	-	6	4
Mont.	-	-	-	-	1	-	25	3	-	-	-
Idaho	1	-	-	-	2	3	102	88	-	2	-
Wyo.	1	-	-	-	-	-	5	1	-	-	-
Colo.	7	26	-	2	1	4	82	69	-	2	-
N. Mex.	16	31	N	N	N	U	44	82	U	-	-
Ariz.	8	10	-	1	2	-	23	153	-	1	3
Utah	119	-	-	2	11	-	14	19	-	-	1
Nev.	5	1	-	17	9	-	22	56	-	1	-
PACIFIC	161	130	4	161	207	60	1,037	608	-	57	25
Wash.	51	19	-	18	10	12	483	209	-	2	1
Oreg.	4	1	-	-	-	-	31	37	-	1	-
Calif.	39	108	3	117	178	48	518	319	-	51	19
Alaska	63	-	-	2	12	-	3	-	-	-	-
Hawaii	4	2	1	24	7	-	22	43	-	3	5
Guam	-	-	U	5	3	U	1	2	U	-	1
P.R.	7	3	-	1	2	-	1	1	-	-	-
V.I.	-	-	U	-	3	U	-	-	U	-	-
Amer. Samoa	-	-	U	-	-	U	-	-	U	-	-
C.N.M.I.	-	-	U	-	-	U	-	-	U	-	-

N: Not notifiable U: Unavailable -: no reported cases

TABLE IV. Deaths in 121 U.S. cities,* week ending September 21, 1996 (38th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	>65	45-64	25-44	1-24	<1	
NEW ENGLAND	479	337	84	40	14	4	23
Boston, Mass.	130	88	24	13	4	1	4
Bridgeport, Conn.	31	22	6	3	-	-	1
Cambridge, Mass.	13	10	3	-	-	-	1
Fall River, Mass.	24	18	5	1	-	-	-
Hartford, Conn.	U	U	U	U	U	U	U
Lowell, Mass.	24	16	7	1	-	-	-
Lynn, Mass.	16	12	4	2	-	-	1
New Bedford, Mass.	22	18	3	1	-	-	1
New Haven, Conn.	47	30	8	4	6	1	2
Providence, R.I.	55	37	13	2	1	2	1
Somerville, Mass.	U	U	U	U	U	U	U
Springfield, Mass.	42	31	6	2	3	-	2
Waterbury, Conn.	21	19	-	2	-	-	2
Worcester, Mass.	52	36	7	9	-	-	8
MID. ATLANTIC	2,190	1,401	472	223	42	39	115
Albany, N.Y.	32	25	6	1	-	-	3
Allentown, Pa.	17	13	4	-	-	-	-
Buffalo, N.Y.	86	59	15	10	-	2	9
Camden, N.J.	25	15	5	5	-	-	1
Elizabeth, N.J.	22	15	6	1	-	-	-
Erie, Pa.§	41	33	6	-	2	-	3
Jersey City, N.J.	33	19	7	4	1	2	-
New York City, N.Y.	1,139	730	248	122	21	18	49
Newark, N.J.	53	19	20	12	1	1	3
Paterson, N.J.	12	6	4	2	-	-	1
Philadelphia, Pa.	400	229	89	45	16	9	23
Pittsburgh, Pa.§	71	44	19	4	1	3	4
Reading, Pa.	12	9	1	1	-	1	1
Rochester, N.Y.	101	76	18	5	-	2	7
Schenectady, N.Y.	13	11	2	-	-	-	-
Scranton, Pa.§	30	26	3	1	-	-	3
Syracuse, N.Y.	69	48	13	7	-	1	8
Trenton, N.J.	15	12	2	1	-	-	-
Utica, N.Y.	19	12	5	2	-	-	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,044	1,357	419	175	53	39	126
Akron, Ohio	53	39	9	4	1	-	-
Canton, Ohio	27	20	6	-	1	-	2
Chicago, Ill.	377	228	79	47	19	3	25
Cincinnati, Ohio	133	88	31	8	2	4	19
Cleveland, Ohio	141	99	24	13	2	3	2
Columbus, Ohio	174	111	42	19	1	1	10
Dayton, Ohio	102	64	29	5	1	3	7
Detroit, Mich.	224	121	53	31	12	7	5
Evansville, Ind.	42	30	11	1	-	-	-
Fort Wayne, Ind.	58	45	9	2	1	1	6
Gary, Ind.	U	U	U	U	U	U	U
Grand Rapids, Mich.	57	40	12	3	-	2	-
Indianapolis, Ind.	219	138	46	20	7	8	18
Madison, Wis.	53	38	9	4	1	1	2
Milwaukee, Wis.	105	82	14	5	2	2	6
Peoria, Ill.	35	24	7	3	-	1	2
Rockford, Ill.	43	32	8	2	-	1	6
South Bend, Ind.	36	23	6	4	2	1	1
Toledo, Ohio	107	85	17	3	1	1	9
Youngstown, Ohio	58	50	7	1	-	-	7
W.N. CENTRAL	725	513	110	48	27	18	31
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	30	17	8	2	2	1	2
Kansas City, Kans.	46	34	6	3	2	1	-
Kansas City, Mo.	77	48	10	2	5	3	4
Lincoln, Nebr.	27	24	3	-	-	-	-
Minneapolis, Minn.	201	147	30	17	5	2	13
Omaha, Nebr.	69	50	12	-	2	5	3
St. Louis, Mo.	114	78	14	11	8	3	-
St. Paul, Minn.	64	47	13	4	-	-	5
Wichita, Kans.	97	68	14	9	3	3	4
S. ATLANTIC	1,180	736	256	117	50	21	51
Atlanta, Ga.	183	112	39	17	10	5	4
Baltimore, Md.	176	103	36	26	8	3	14
Charlotte, N.C.	60	39	15	3	3	-	2
Jacksonville, Fla.	120	85	20	9	5	1	4
Miami, Fla.	109	73	22	10	2	2	1
Norfolk, Va.	64	30	14	9	7	4	1
Richmond, Va.	72	45	16	8	3	-	2
Savannah, Ga.	60	40	13	4	1	2	3
St. Petersburg, Fla.	43	29	11	2	1	-	6
Tampa, Fla.	167	115	33	15	2	2	13
Washington, D.C.	113	57	32	14	8	2	1
Wilmington, Del.	13	8	5	-	-	-	-
E.S. CENTRAL	734	464	153	73	25	18	51
Birmingham, Ala.	106	61	20	12	7	5	2
Chattanooga, Tenn.	59	34	16	5	2	2	6
Knoxville, Tenn.	78	58	14	3	1	2	6
Lexington, Ky.	61	43	9	7	-	2	5
Memphis, Tenn.	186	118	41	18	8	1	18
Mobile, Ala.	80	47	15	12	1	5	-
Montgomery, Ala.	37	27	8	1	-	1	3
Nashville, Tenn.	127	76	30	15	6	-	11
W.S. CENTRAL	1,381	866	288	132	61	34	59
Austin, Tex.	76	43	14	11	7	1	2
Baton Rouge, La.	58	34	14	5	2	3	3
Corpus Christi, Tex.	39	31	5	3	-	-	-
Dallas, Tex.	195	115	44	23	7	6	3
El Paso, Tex.	86	63	15	6	1	1	2
Ft. Worth, Tex.	96	57	18	9	6	6	-
Houston, Tex.	292	173	61	33	16	9	26
Little Rock, Ark.	51	32	16	1	-	2	3
New Orleans, La.	135	76	24	22	12	1	-
San Antonio, Tex.	174	112	46	8	6	2	7
Shreveport, La.	81	56	14	7	2	2	10
Tulsa, Okla.	98	74	17	4	2	1	3
MOUNTAIN	848	540	169	84	30	24	51
Albuquerque, N.M.	67	45	10	6	2	4	2
Colo. Springs, Colo.	58	38	10	7	2	1	4
Denver, Colo.	110	70	21	12	4	3	7
Las Vegas, Nev.	208	122	52	25	3	6	9
Ogden, Utah	16	14	1	1	-	-	-
Phoenix, Ariz.	148	89	31	13	8	7	12
Pueblo, Colo.	30	18	9	2	-	1	1
Salt Lake City, Utah	85	58	10	9	8	-	8
Tucson, Ariz.	125	86	25	9	3	2	8
PACIFIC	1,900	1,297	352	156	51	44	141
Berkeley, Calif.	8	5	1	1	-	1	-
Fresno, Calif.	99	63	12	12	6	6	3
Glendale, Calif.	48	38	7	2	-	1	3
Honolulu, Hawaii	91	69	13	7	-	2	9
Long Beach, Calif.	63	43	10	8	1	1	10
Los Angeles, Calif.	611	429	98	56	17	11	25
Pasadena, Calif.	30	19	6	2	1	2	3
Portland, Oreg.	127	92	19	7	8	1	10
Sacramento, Calif.	215	134	56	15	3	7	20
San Diego, Calif.	142	88	36	12	3	3	20
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	168	118	36	10	2	2	20
Santa Cruz, Calif.	36	27	4	4	-	1	5
Seattle, Wash.	127	81	27	11	5	3	3
Spokane, Wash.	48	37	7	2	1	1	3
Tacoma, Wash.	87	54	20	7	4	2	7
TOTAL	11,481¶	7,511	2,303	1,048	353	241	648

U: Unavailable -: no reported cases

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

§Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

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